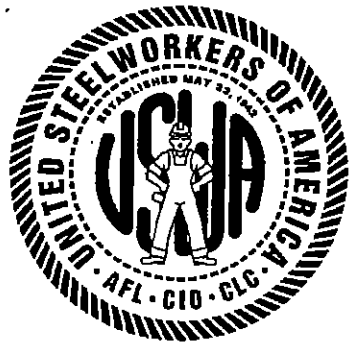
PIRELLI ARMSTRONG TIRE CORPORATION RETIREE MEDICAL BENEFITS TRUST

SUMMARY PLAN DESCRIPTION



Effective January 1, 1998

EXHIBIT
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INTRODUCTION TO NEW BENEFIT BOOKLET (SUMMARY PLAN DESCRIPTION)

PIRELLI ARMSTRONG TIRE CORPORATION RETIREE MEDICAL BENEFITS TRUST

TO: All Covered Beneficiaries

We are very pleased to provide to you at this time a new benefit booklet describing in detail the Pirelli Armstrong Tire Corporation Retiree Medical Benefits Trust Plan of Benefits. This booklet explains how all covered beneficiaries can maintain eligibility for benefits under the Fund, describes many of the benefits, and provides certain other important information to you.

This booklet has been organized into two major sections to make it easier to use. The first section contains information applicable to all retirees and surviving spouses and their beneficiaries who are covered under the plan. This section contains a description of the rules of eligibility for participation in the plan as well as the claims review and appeal procedures to be used in appealing a denied claim under the Plan. Included as well are certain rights prescribed for all beneficiaries by federal law and other important miscellaneous information.

The second section of this booklet contains information for those individuals whose benefits are provided directly from the Fund. These benefits are generally referred to as "self-funded" benefits. If your benefits are provided through an insurance policy, whether under a health maintenance organization or through another arrangement, you should have received separate information describing those benefits. The benefits described in the second section of this booklet apply only to those beneficiaries whose benefits are not insured. However, if you have supplemental drug coverage which is self-funded, those benefits are described under the Standard Medical Benefits.

Once you have had an opportunity to review this booklet, please place it with your important papers for safekeeping. You should refer to it before incurring any expenses which you anticipate will be covered by the Fund.

If you should have absolutely any questions regarding any provisions of this new benefit booklet, we would urge you to contact the Fund administration office for assistance.

Best regards,

Your Benefits Board

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SECTION ONE

INFORMATION APPLICABLE TO ALL FUND BENEFICIARIES

PIRELLI ARMSTRONG TIRE CORPORATION
RETIREE MEDICAL BENEFITS TRUST

The Trust is administered by the Benefits Board. The Board members are:

Mr. Robert Fly
12th Pecan Way
Natchez, Mississippi 39120

Mr. John Johnson
5075 Thomas Street
Clarksville, Tennessee 37043

Mr. Donald J. Jewell
137 Porter Lane
Orange, Connecticut 06477

Mr. Lewis "Sonny" Milton
P. O. Box 83
Hanford, California 93232
213 West 7th Street
Hanford, California 93230

Mr. Earl W. Seymour
State of Iowa Employment Appeal Board
Lucas State Office Building
Des Moines, Iowa 50319

Administrative services are provided to the Trust by:

Southern Benefit Administrators, Incorporated
P. O. Box 1449
Goodlettsville, Tennessee 37070-1449
Phone: (615) 859-0131
Toll-Free: (800) 831-4914
Fax: (615) 859-0818

The Fund Attorney is:

Mr. George E. Barrett
Barrett, Johnston and Parsley
217 Second Avenue North
Nashville, Tennessee 37201-1697
Phone: (615) 244-2202

ELIGIBILITY FOR BENEFITS

Benefits are provided under this plan for certain retired hourly employees of the Pirelli Armstrong Tire Corporation, and their spouses, or surviving spouses, and eligible Dependent Children (as defined in this section). The rules for maintaining eligibility for benefits under the plan are outlined below.

WHEN ELIGIBILITY BEGINS

Coverage under the plan is offered to all qualifying beneficiaries. Beneficiaries include retirees, their legal spouses or surviving spouses, and their Dependent Children. For all beneficiaries not eligible for Medicare benefits, or for Medicare eligible beneficiaries enrolling for the Standard Medical Plan or the Prescription Drug Only Plan outlined in this booklet, coverage became effective January 1, 1998, provided timely enrollment information was received in the Fund office. For all other beneficiaries eligible for and enrolling for the coverage on a timely basis, benefits became effective under this plan on February 1, 1998.

If an individual first becomes a legal spouse or Dependent Child of a retiree after the effective date outlined above, eligibility for that individual will begin on the date he or she first qualifies as a spouse or Dependent Child, provided timely enrollment information is received in the Fund office.

WHAT BENEFITS ARE PROVIDED

This booklet contains a schedule of benefits available for plan beneficiaries who are not eligible for Medicare. Included as well are a standard medical plan available to Medicare eligible beneficiaries and an optional prescription drug only plan which is offered as an alternative to Medicare eligible beneficiaries. The benefits available under these Schedules of Benefits are paid direct from the Fund office.

As an alternative to the benefits outlined in this booklet, a plan of insured benefits is offered in many areas covered under the plan. These alternative Schedules of Benefits which are provided by health maintenance organizations (HMOs) are not available in all areas. Therefore, some beneficiaries under the plan do not have alternative benefits from which to choose.

When you first became eligible to participate under this plan, you were furnished with an explanation of the benefit alternatives available to you, and the method for choosing benefits, if applicable.

If your eligibility for Medicare benefits changes, or the Medicare status of one of your dependents changes, you should contact the Fund office to change your benefit enrollment. Otherwise, you can change your benefit coverage only if you are covered under an HMO, and the HMO offers a period of open enrollment.

CONTINUATION OF COVERAGE

Coverage for each qualified beneficiary will continue as long as the appropriate direct contribution is received in his or her behalf. Monthly contributions are required to continue the coverage of each retiree, spouse or surviving spouse.

The amount of the contribution required from beneficiaries under the plan is established by the Benefits Board. Each retiree or surviving spouse who is receiving a pension from the PTC Retirement Pension Plan may file a form authorizing the administrator of that plan to deduct the required monthly contribution due to this Fund and to make that payment direct to this Fund. All other qualified beneficiaries must make payments direct to the Fund in their behalf. For those individuals making direct contributions, a contribution notice is mailed each quarter. For the convenience of covered beneficiaries, contributions may be made monthly or quarterly.

In the event a change in the monthly contribution amount becomes necessary, all qualified beneficiaries will be notified in advance.

If the required contribution is not received on time in behalf of any beneficiary, his or her coverage will terminate on the first day of the month for which he or she fails to make the appropriate payment. However, if the contribution is not paid timely due to circumstances beyond the control of the beneficiary, a late contribution may be accepted to reinstate eligibility, provided:

1. The payment is made as soon as reasonably possible;
2. The payment is accompanied by an explanation of the reason for the delay; and
3. The late contribution is approved upon review by the Benefits Board or their committee.

Otherwise, coverage may not be regained by a terminated beneficiary.

Coverage for Dependent Children will continue without charge only so long as the retiree or surviving spouse continues to make the monthly payment required for his or her continuing eligibility.

COVERAGE FOR DEPENDENT CHILDREN

As explained above, coverage for Dependent Children (as defined in this section of the booklet) will continue as long as the retiree or surviving spouse continues to be eligible under the Fund through regular monthly contributions.

Dependent Children are covered up to age nineteen. However, if a Dependent Child continues to be a full-time unmarried student who is wholly dependent on the retiree or surviving spouse for care and support, coverage will be continued until attainment of age twenty-five. Please see the definition of "Eligible Dependent" at the end of this section.

ENROLLMENT OF ADDITIONAL DEPENDENTS

If a retiree first acquires a spouse or Dependent Child after he has become eligible for benefits under this plan, he must enroll that new beneficiary within thirty-one days of the date on which he is first eligible to do so. A surviving spouse may not enroll any dependents other than Dependent Children who qualified as children of the deceased retiree.

SUSPENSION OF COVERAGE

If any beneficiary who qualifies for benefits under this Fund has other health coverage, either through insurance or a federal program, that beneficiary may choose to suspend coverage under this Fund. The beneficiary can do so by completing an enrollment form available from the Fund office.

In order to activate coverage under this plan, the beneficiary must notify the Fund office in writing of his desire to re-enroll for coverage under the plan. If the other coverage is provided through a federal program, coverage can be activated under this plan on the first day of any month. If the other coverage is provided through insurance, coverage under this plan can only be activated following the termination of the other coverage.

TERMINATION OF COVERAGE

Coverage for each beneficiary will terminate on the earliest of the following:

1. The first day of any month for which the required contribution is not received on a timely basis;
2. The last day of the month in which a child ceases to meet the definition of Dependent Child as outlined in this section;
3. The last day of the month in which a Surviving Spouse remarries;
4. For the spouse of a retiree, the date of divorce from the retiree;
5. The date on which any information required to certify continued coverage for eligibility under this Fund is not received in the Fund office, as required by the Benefits Board; or
6. The date on which the trust terminates or the beneficiary dies.

Regardless of these provisions, coverage for a Dependent Child will not be terminated due to the re-marriage of a surviving spouse who is the parent of that child, nor will it be terminated on the death of the Dependent Child's parent who is a beneficiary under the Fund.

NO DUPLICATE COVERAGE UNDER THE FUND

Each beneficiary eligible for benefits under this plan will be eligible only as a retiree, spouse, surviving spouse or Dependent Child. No duplicate coverage will be provided to any person who may qualify under more than one category of beneficiary as outlined in this section.

ELIGIBILITY FOR PREGNANCY RELATED BENEFITS

Pregnancy related expenses are covered only if incurred by a retiree or the spouse of a retiree. No pregnancy related benefits are provided for surviving spouses or Dependent Children.

"DEPENDENT CHILD" DEFINED

The term "Dependent Child" means an individual, as outlined below, who is the child of a retiree or a surviving spouse on the effective date of coverage for the retiree or surviving spouse. "Dependent Child" also includes an individual, as outlined below, who first becomes a Dependent Child of a retiree after the effective date of the retiree's coverage. As used in this booklet, "Dependent Child" includes:

1. Each unmarried child of a retiree or surviving spouse from birth to the age of nineteen years, provided the child is not covered under the Fund as a retiree or surviving spouse and is dependent on the retiree or surviving spouse for his support. The term "Dependent Child" includes a stepchild, foster child, legally adopted child and a child who is the retiree or surviving spouse's legal ward.

   Foster children and legal wards of the retiree or surviving spouse will only be considered Dependent Children provided permanent custody of the foster child or legal ward has been granted to the retiree or surviving spouse by court order or by a governmental agency. A stepchild, legally adopted child, foster child or legal ward will be considered a Dependent Child of the retiree or surviving spouse only if the child:

   a. lives with the retiree or surviving spouse in a regular parent-child relationship;
   b. receives full financial support from the retiree or surviving spouse;
   c. is dependent on the retiree or surviving spouse for health care protection; and
   d. is claimed as a dependent on the retiree's or surviving spouse's federal income tax return.

   Coverage will be provided for a step-child, legally adopted child, foster child or legal ward only if the retiree or surviving spouse provides written verification of that child's relationship to the retiree or surviving spouse as required by the Trustees from time to time. Coverage for foster children will be provided only

to the extent of covered medical expenses which are not furnished or paid for by a Federal or state program.

2. Any child described in 1. above who has attained age 19 but who has not yet attained age 25, provided the child;
   a. is a registered student in regular full-time attendance at a school,
   b. is wholly dependent on the retiree or surviving spouse for care and support, and
   c. remains unmarried.
3. Any child less than nineteen years of age who has been placed with a retiree or surviving spouse for adoption, but the adoption has not become final. Being placed for adoption means that the retiree or surviving spouse has assumed, and retains, a legal obligation for total or partial support of such child in anticipation of adoption of the child. The child's placement with the retiree or surviving spouse terminates upon termination of such legal obligation. Upon an adoption becoming final the child may continue to meet this definition of Dependent Child.
4. Any child of a retiree or surviving spouse as defined under 1. or 2. above but who passes the limiting age, and who as of such date is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the retiree or surviving spouse for support or maintenance. To qualify, proof of such incapacity and dependency must be furnished to the Benefits Board within 31 days of the child's attainment of the limiting age and at such times as may be required by the Benefits Board, but not more frequently than annually.

CLAIMS REVIEW AND APPEALS PROCEDURE

Many participants in this Fund have their health benefits provided through arrangements with insurance companies. For others, benefits are paid directly from the Fund, as described in this booklet. However, it is important for all participants to be aware of their right to have any denied claims reviewed for a final determination.

For those of you whose benefits are provided through an insurance policy, you should have already been provided with a claims review and appeals procedure with the appropriate insurance carrier. For the remainder of you, your right to have a denied claim reviewed by the Benefits Board is outlined below. **However, for any claim which is denied due to a question of eligibility for benefits under the Fund, you have a right to an appeal to the Benefits Board, regardless of whether your benefits are insured or self-funded. Such an appeal would be limited to the question of eligibility.**

REVIEW BY CLAIMS OFFICE

If your claim for a benefit is denied by the Fund office, you will receive a written explanation of the reason for the denial. If, after reading the explanation, you feel that the action taken on your claim may be unjustified, or you do not understand the reason for the denial, you should immediately ask the Fund office to review your claim with you. At that time, the Fund office will let you know if there is any additional information which might enable you to have your claim reconsidered for payment.

If you are still not satisfied with the action taken on your claim, you have the right to appeal your claim to the Benefits Board. The procedures for appeal are set forth below.

APPEAL TO BENEFITS BOARD

1. Within 90 days after you receive written notice that your claim has been denied, or within 90 days after the Fund office has received a claim from you on which it has failed to take action, you or your representative may make a written request for a review to:

Benefits Board
Pirelli Armstrong Tire Corporation
Retiree Medical Benefits Trust
P. O. Box 1449
Goodlettsville, TN 37070-1449
Phone: (615) 859-0131
Toll Free: (800) 831-4914
Fax: (615) 859-0818

2. You must request **in writing** a review of the denial by the Benefits Board, or their designated committee. You may submit facts in support of your claim and the reason you believe the original decision was incorrect.

3. In preparing your written request for review, you may review all pertinent documents relating to the claim and its denial. In addition, the Fund office staff will assist you in gathering any information required from Fund records necessary for the appeal. It will generally be in your best interest to submit as much detail as possible regarding the reasons you think the claim should be approved.

4. You may elect in your written request for review to have the issue decided on the basis of a written appeal, to appear before the Benefits Board or the Claims Committee to personally present the appeal, or to designate a personal representative to appear in your behalf. If you elect a written appeal, you can later elect a personal appeal as outlined in these procedures.

5. If you elect to defer your right to personal presentation of the appeal, or to permanently waive that right, the Fund administrative staff will present all written statements, materials and other pertinent information to the Benefits Board on your behalf.

6. You will be notified in writing of the decision. The written notice of the decision will contain the reasons for the decision and specific references to the pertinent plan provisions on which the decision was based.

7. The decision will be made by the Benefits Board promptly and, except as outlined in the following sentences, not later than 60 days after receipt of your request for review, or within 120 days if a personal hearing is requested.

   If the Benefits Board or its committee has scheduled a regular quarterly meeting past the 60 day period outlined above, and the request is received at least 7 days prior to that meeting, a decision on the request will be made no later than the date of that meeting. If the request is received less than 7 days prior to that meeting, a decision may be delayed until the second meeting of the Board or Committee following receipt of your request.

   If the decision of the Benefits Board is to support the original denial, and you elected in your original request for review to defer a personal appearance before the Board, the written notice of the decision will also notify you of your right to appear in person before the Benefits Board. You will then have an additional 90 days in which to elect a personal appeal. The personal hearing will be scheduled as outlined in the previous paragraphs. The Fund office staff will notify you of the date, time and location of the hearing.

8. You may, at your own expense, have legal representation at any stage of this claims appeal process.

9. Maximum effort will be made by the Benefits Board to interpret plan provisions

in a consistent and equitable manner, and you will be given an opportunity for review of any denied claim by the Benefits Board or its Claims Committee.

10. It is the position of the Benefits Board that every participant and beneficiary will be required to exhaust each and every right of recourse available under these claims review and appeal procedures before the participant or beneficiary proceeds to litigation, and any attempt to circumvent or subvert these claims review and appeals procedures in any manner will be resisted by the Benefits Board.

RIGHTS OF PLAN PARTICIPANTS

As a participant in the Pirelli Armstrong Tire Corporation Retiree Medical Benefits Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Fund Office and at other locations such as union halls, all Plan Documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

   Examination of the documents, agreements or reports may be made at the Fund Office during normal business hours provided you have given the office staff at least 3 days prior written notice of your desire to examine these materials and have specified what materials you wish to review. This procedure permits the Fund Office to process your request expeditiously and to have the requested information ready when you arrive.

   Also, upon written request to the Fund Office, the material will be made available within ten days at an applicable local union office.

2. Obtain copies of all Plan Documents and other plan information upon written request to the Fund Office. Under ERISA, the Fund may make a reasonable charge for the actual cost of reproducing the documents and other information.

3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

4. In addition to creating rights for plan participants, ERISA defines the duties of the people who are responsible for the operation of the employee benefit plan.

   The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the exclusive interest of you and other plan participants and beneficiaries.

5. No one may take any action which would prevent you from obtaining a benefit to which you are entitled under this plan or from exercising your rights under ERISA.

6. In accordance with Section 503 of ERISA and federal regulations, the Benefits Board has adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim. These procedures appear in this booklet.

   If your claim for a health benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial.

   Then, if you are not satisfied with the action taken on your claim, you have the right to have the Benefits Board review and reconsider your claim in accordance with the plan's claims review procedures.

7. Under ERISA, there are steps which you can take to enforce the above rights.
   (a) For instance, if you request materials from the plan and do not receive them within 30 days, the court may require the plan to provide the materials and pay you up to $110.00 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator.
   (b) If you have a claim for benefits which is denied or ignored, you may file suit in a state or Federal court.

   However, before exercising this right, you will normally find it advisable to exhaust all the claim review procedures provided under the plan and proceed only upon the advice of counsel.

8. If you feel the plan fiduciaries may be misusing the plan's money or are discriminating against you for asserting your rights under ERISA, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court.
   (a) The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.
   (b) If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim is frivolous.

9. If you have any questions about your plan, you should contact the Benefits Board at the following address:

   Benefits Board
   Pirelli Armstrong Tire Corporation
   Retiree Medical Benefits Trust
   P. O. Box 1449
   Goodlettsville, Tennessee 37070-1449

10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

OTHER IMPORTANT INFORMATION

1. This Booklet is Only a Summary

Although this booklet contains a great deal of information about your plan, it is not the purpose of this booklet to cover every detail or every situation that might arise under your health plan.

However, there is a complete set of rules and regulations which govern the operation and administration of this plan. These rules and regulations are set forth in a legal document referred to as the Plan Document.

The rules and regulations set forth in the Plan Document are final and binding. Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan Document itself. If there is any difference between the Plan Document and the summary in this booklet, the Plan Document will control.

2. The Benefits Board Interprets the Plan

Any interpretation of the Plan's provisions rests with the Benefits Board. However, the Board has authorized the contract administrator and its staff to handle routine requests from participants regarding eligibility rules, benefits and claims procedures. But, if there are questions involving interpretation of any plan provisions, the administrator will secure from the Benefits Board a final determination for you. No person other than a Benefits Board member or an employee of the contract administrator, acting with the consent of the Benefits Board, may provide interpretations of plan provisions.

3. The Plan May Be Changed

The Benefits Board is endowed with the authority to change the plan. Although the Board members expect to maintain benefits, this can only be done within the limits of available financial resources. The Board has an obligation to make whatever plan changes are necessary to assure the financial stability of this plan.

The Benefits Board also may change the plan in any way to protect its tax exempt status under the Internal Revenue Service rules. From time to time, these rules may change and certain plan provisions may be amended in order to preserve the tax exempt status of your plan.

4. Termination of Plan

The following information regarding the conditions under which the Fund may be terminated, and the disposition of the assets of the Fund on termination, are furnished in accordance with federal laws and regulations.

The Fund will be terminated upon the termination of the trust agreement establishing the Fund. The trust agreement may be terminated by the Benefits Board. Upon termination of the trust, the trust Fund will be paid out by the Fund trustee in the following order of priority:

(a) administrative expenses incurred by the trustee in connection with the administration and termination of the trust;

(b) any and all taxes for which the trust is or will be liable;

(c) funding of benefits under the Plan; and

(d) either:

(i) a transfer to a trust which benefits all of the beneficiaries of this Fund, provided that any such trust or trusts have received a determination letter from the IRS acknowledging qualification under the Internal Revenue Code; or

(ii) if no such trust meets the requirements of (i) above, then a cash distribution to the Fund beneficiaries in such proportions as determined by the Benefits Board with approval of the union general counsel to be fair and equitable.

Under no condition will the termination of the Trust result in a distribution to the corporation or affiliate of the corporation.

5. Name and Address of the Plan Administrator as Defined by the Employee Retirement Income Security Act of 1974

Your Plan is administered by a Benefits Board consisting of five members. A list of all of the Board members as of the date this booklet was prepared is found in the front portion of this booklet.

This Board has the primary responsibility for decisions regarding eligibility rules, type of benefits, administrative policies, management of Plan assets, and interpretation of Plan provisions.

Any communication with the Benefits Board should be addressed to the Fund office at:

Benefits Board
Pirelli Armstrong Tire Corporation
Retiree Medical Benefits Trust
P. O. Box 1449
Goodlettsville, Tennessee 37070-1449

6. Type of Administration

Although the Board Members are legally designated as the Plan Administrator, they

have delegated the performance of the day-to-day administrative duties to a professional Administrative Manager, Southern Benefit Administrators, Incorporated.

The Fund office staff maintains the eligibility records, accounts for contributions, processes claims, informs participants of Plan changes, and performs other routine administrative functions in accordance with Board decisions.

7. Funding of the Trust

The primary source of funding for the benefits provided through this Trust is a lump sum payment from the Pirelli Armstrong Tire Corporation in settlement of a class action lawsuit brought by certain former employees of that corporation. Additional funding comes from the monthly payments required from covered beneficiaries and from earnings on the assets of the Trust.

All payments, contributions and earnings are accumulated in the Trust Fund. Some benefits are provided direct from Fund assets and some benefits are provided through contracts of insurance. Insured benefits are described more fully in separate printed information distributed to all affected beneficiaries.

8. Agent for Service of Legal Process

Every effort will be made by the Benefits Board to resolve any disagreements with covered beneficiaries promptly and equitably. It is recognized, however, that on a few occasions, some individuals may feel that it is necessary for them to take legal action. Be advised that the following has been designated by the Benefits Board as their Agent for service of legal process:

Mr. George E. Barrett
Barrett, Johnston and Parsley
217 Second Avenue North
Nashville, Tennessee 37201-1697

Or legal papers may also be served on the Benefits Board collectively or individually as well as the Fund office manager.

9. Recognition of Qualified Medical Child Support Orders

In accordance with resolutions and procedures adopted and established by the Benefits Board, the Board will recognize a Qualified Medical Child Support Order, as that term is defined in the Omnibus Budget Reconciliation Act of 1993. Regardless of any other provisions to the contrary, benefits may be assigned by the custodial parent or legal guardian of an Alternate Recipient, as that term is defined in the aforementioned Act. Additionally, any benefits otherwise payable for Covered Medical Expenses paid by an Alternate Recipient, or his or her custodial parent or legal guardian, will be paid to such Alternate Recipient, custodial parent or legal guardian.

In providing notice and proof of claim, and any such other information as may be required by the Benefits Board in determining the proper disposition of a claim for benefits, the custodial parent or legal guardian of an Alternate Recipient may act in place of the covered Beneficiary, unless it is otherwise deemed improper to do so by the Benefits Board.

10. Plan Identification Numbers

When filing various reports with the Department of Labor and the Internal Revenue Service, certain numbers are used to properly identify the Fund including:

Employer Identification Number (EIN)
assigned by the Internal Revenue Service 62-171724
Plan Number 50

11. Fiscal Year

The accounting records of this Plan are kept on the basis of a fiscal year which end on December 31st.

SECTION TWO

SELF-FUNDED BENEFITS APPLICABLE TO BENEFICIARIES WHOSE BENEFITS ARE PAID DIRECT FROM THE FUND

HOW TO FILE A CLAIM

To assist the Fund office in processing your claims as quickly as possible, please follow the steps outlined below in the order in which they appear. You should file a completed claim form for each new illness or injury for which medical services are received. You should file a claim form at least once a year for an ongoing illness or injury.

Be sure you have your health benefit identification card with you at all times. It is especially important that you have this card available for hospital admittances or when you visit a physician or other service provider:

Step 1: If you are not a Medicare eligible beneficiary, hospital pre-admission certification is required. When you have advance knowledge that you or one of your eligible dependents is going to require hospitalization, you should contact the National Preferred Provider Network (NPPN) prior to hospitalization at 1-800-318-6776. If you or your dependent are admitted to a hospital on an emergency basis, NPPN should be notified within 48 hours after admission. Hospital pre-certification is required regardless of whether the hospital is a participating PPO hospital.

Step 2: Secure the proper claim form from the Fund office. The office can be contacted at 1-800-831-4914.

Step 3: Fill out the claim form completely, providing all of the requested information, and sign it.

Step 4: Attach itemized bills from each medical service provider (doctors, hospitals, etc.). Do not send monthly billing statements. Only detailed itemized bills contain sufficient information to process the claim.

Step 5: Mail the claim to the Fund office at: Pirelli Armstrong Tire Corporation Retiree Medical Benefits Trust, P. O. Box 1449, Goodlettsville, Tennessee 37070-1449.

NOTICE AND PROOF OF CLAIMS

A written notice of any injury or illness for which an individual is making claim, and all forms, bills and information necessary to pay the claim, must be provided to the Fund office within 90 days following the end of the calendar year in which the claim is incurred.

When the Fund office receives notice of a claim, it will furnish forms for the filing of the claims. If the forms are not furnished within 15 days after receipt of the notification of a claim, the claimant will be considered to have complied with all requirements of the plan for submitting claims on a timely basis.

ASSIGNMENT OF BENEFITS

Benefits which are payable under this plan and which have not been assigned to a provider of covered services will be paid to the retiree (or surviving spouse). However, if benefits are being provided under a Qualified Medical Child Support Order (as established under the Omnibus Budget Reconciliation Act of 1993), benefits which are not assigned will be paid to the custodial parent or legal guardian of the dependent child for whom the benefits are provided.

A covered individual may assign benefits which are payable under this plan, but only to a physician, hospital or other health care facility. If benefits are provided under a Qualified Medical Child Support Order, those benefits may be assigned by the custodial parent or legal guardian of the dependent child. Benefit assignments made in accordance with any state Medicaid law will also be honored by the plan.

PAYMENT OF BENEFITS

Benefits are payable to the retiree or surviving spouse even if the claim is on a dependent child. However, if benefits are assigned, they will be paid to the assignee instead of directly to the retiree or spouse. Benefits are payable when the required forms have been submitted to the plan.

If an individual is, in the opinion of the Benefits Board, not capable of giving a valid receipt for payments due, and no guardian has been appointed for that person, the Board may make payment to the individual or individuals who, in their opinion, have assumed the care and principal support of that person. If the individual should die before all amounts that are due have been paid, the Benefits Board may, at its option, make payment to the executor or administrator of the estate of the individual or to his surviving spouse, parent, child or children or to any individual who, in the Board members' opinion, is entitled to the benefits.

Any payments that are made in accordance with these provisions will fully discharge the liability of the Benefits Board to the extent of the payments made.

ILLEGAL OCCUPATION OR COMMISSION OF FELONY

The plan will not be liable for loss to which a contributing cause is the commission of or attempt to commit a felony by the person whose injury or sickness is the basis of claims, or to which a contributing cause is such person's having been engaged in an illegal occupation.

STANDARD MEDICAL BENEFITS FOR BENEFICIARIES NOT ELIGIBLE FOR MEDICARE

These benefits are provided to eligible beneficiaries who have not chosen to be covered through a health maintenance organization. (HMOs are not available in all areas covered by the fund.)

SCHEDULE OF BENEFITS

BENEFIT	PPO IN-NETWORK COVERAGE	PPO OUT-OF-NETWORK COVERAGE AND OUT-OF-AREA COVERAGE
Calendar Year Deductible:		
Per Individual	$250.00	$ 500.00
Maximum Per Family	$500.00	$1,000.00
Out-of-Pocket Maximum Per Calendar Year:*		
Per Individual	$1,000.00	$2,500.00
Maximum Per Family	$2,000.00	$5,000.00
Co-Payment Percentage for All Covered Medical Expenses Except Prescription Drugs	80%	60%
Co-Payment for Prescription Drugs Dispensed by a Network Pharmacy:		
For Generic and Brand Name Drugs Listed on the Network's Preferred List	$ 7.00	No Coverage
For All Other Brand Name Drugs, When Medically Necessary	$12.00	No Coverage
Maximum Lifetime Benefit per Individual	$1,000,000.00	$1,000,000.00

*Expenses which exceed the Plan's Covered Medical Expenses are not counted toward the Out-of-Pocket Maximum. The Calendar Year Deductible does count toward the Out-of-Pocket Maximum.

BENEFIT	PPO IN-NETWORK COVERAGE	PPO OUT-OF-NETWORK COVERAGE AND OUT-OF-AREA COVERAGE
Other Limits:		
For Ambulance Service per Hospitalization	$500.00	$500.00
In-Patient Mental Health/Substance Abuse Treatment	60 Days Per Year	60 Days Per Year
Out-Patient Mental Health/Substance Abuse Treatment	40 Visits Per Year	40 Visits Per Year
For Treatment By or Under the Supervision of a Doctor of Chiro-practic (D.C.)	20 Visits Per Year	20 Visits Per Year
For Occupational Therapy and Physical Therapy Combined	60 Visits Per Year	60 Visits Per Year
For Speech Therapy	40 Visits Per Year	40 Visits Per Year
For Treatment in an Extended Care Facility	100 Days Per Year	100 Days Per Year
For Home Health Care	120 Days Per Year	120 Days Per Year
Maximum Hospital Room and Board Rate	Actual Semi-Private Room Rate, or, Actual Private Room Rate if no Semi-Private Room is Available, otherwise Average Semi-Private Room Rate if Private Room is Utilized	Actual Semi-Private Room Rate, or, Actual Private Room Rate if no Semi-Private Room is Available, otherwise Average Semi-Private Room Rate if Private Room is Utilized

EXPLANATION OF BENEFITS

(Refer to Benefits Definitions for important information regarding this coverage. Defined terms are capitalized.)

Medical benefits become payable if a Medicare eligible beneficiary incurs Covered Medical Expenses in excess of the calendar year deductible amount. The deductible amount, maximum out-of-pocket amount, co-payment percentages and maximum benefits are summarized in the Schedule of Benefits and are described in more detail on the following pages.

CALENDAR YEAR DEDUCTIBLE AMOUNT

The calendar year deductible amount is the amount of Covered Medical Expenses which are the responsibility of the covered beneficiary and the amount which must be met before any expenses become payable under this plan. Only Covered Medical Expenses (see definitions) may be used to meet the calendar year deductible. This deductible must be met for each calendar year.

OUT-OF-POCKET MAXIMUM AMOUNT

The out-of-pocket maximum amount is the maximum amount of Covered Medical Expenses for which a beneficiary will be responsible in any calendar year. Once a total of co-payment amounts and the calendar year deductible reach the out-of-pocket expense, the payment percentage to be applied to any additional Covered Medical Expenses will be increased to 100%.

CO-PAYMENT PERCENTAGE

Once the calendar year deductible amount has been satisfied by a covered beneficiary, the plan will pay the co-payment percentage outlined in the Schedule of Benefits of the Covered Medical Expenses incurred by that person during the remainder of that calendar year, subject to the out-of-pocket maximum amount.

MAXIMUM LIFETIME BENEFIT

The maximum lifetime benefit available to each covered beneficiary is specified in the Schedule of Benefits. Any benefit payments made at any time under this plan will be used in determining the maximum lifetime benefit.

REINSTATEMENT OF MAXIMUM LIFETIME BENEFIT

On January 1 of each year, each beneficiary who has had Covered Medical Expenses paid in his behalf will have his remaining maximum lifetime benefit increased. The amount of the increase will be:

1. the amount to restore that beneficiary's full maximum, if less than $5,000; or
2. $5,000, if more than $5,000 is required to restore the full maximum benefit.

This reinstatement of lifetime benefit provision cannot increase the maximum above the maximum lifetime benefit set forth in the Schedule of Benefits. This provision means that if a beneficiary has exhausted his complete maximum amount and continues to incur expenses, he will receive up to $5,000 in benefits in each calendar year in which he is eligible for benefits.

USE OF PREFERRED PROVIDER ORGANIZATION (PPO)

The Fund uses the services of the National Preferred Provider Network (NPPN) to help provide quality health care at affordable prices to plan participants. A preferred provider organization (PPO) is a network of health care providers including doctors, hospitals and other facilities which provide services at discounted or fixed rates. By securing your health care services from a participating provider, you can ensure that you will receive the maximum benefit available under the Fund. You may of course choose to receive services from a non-participating provider, but in such case, you will be subject to a much lower level of reimbursement, as reflected in the Schedule of Benefits.

To receive the maximum benefit available under the Fund, you should always consider using participating providers. A directory of participating providers should have been furnished to you already. If you have not received a directory, please contact the Fund office. If you would like to verify that a particular doctor or hospital is still participating in the PPO, you may contact the fund office or contact the PPO direct at 1-800-318-6776.

You should consider the following when seeking health care services:

1. When hospitalization becomes necessary, ask your doctor to admit you to a participating Hospital.
2. If you need to see a specialist, ask your doctor to refer you to a participating provider.
3. Before a Hospital stay, confirm that the anesthesiologist, pathologist and radiologist providing services to you in the Hospital or in the surgical center are participating providers.
4. If your doctor performs tests on you and sends those to an outside laboratory, confirm that the laboratory is a participating facility.

Remember, to receive the maximum benefits available under the Fund, and to avoid substantial financial penalties, you should always attempt to be treated by a participating Physician and at participating facilities.

HOSPITAL PRE-ADMISSION CERTIFICATION

Hospital Pre-Admission Certification is required for all Hospital admissions, whether you are being admitted to a PPO Hospital or a non-participating Hospital. You or your Physician, or someone else in your behalf, must contact the National Preferred Provider Network (NPPN) for pre-admission certification at 1-800-318-6776. For non-emergency hospital admissions, you must call before entering the Hospital. For emergency Hospital admissions, NPPN must be called within 48 hours after you are admitted to the Hospital.

COVERED MEDICAL EXPENSES

Covered expenses include only "Covered Medical Expenses" (see Benefits Definition Section) which are furnished upon the recommendation and approval of the attending Physician.

Covered Medical Expenses will consist only of the lesser of (i) the Usual, Customary and Reasonable Expense, or (ii) the applicable payment amount negotiated by the preferred provider organization as referred to on the previous page. Expenses in excess of this amount will not be considered a Covered Medical Expense.

Covered Medical Expenses are those charges listed below, subject to the limitations outlined in the Schedule of Benefits:

1. Charges made by a Hospital for:
   a. Room and board, up to the amount listed in the Schedule of Benefits. Room and board charges in excess of this daily limit will not be considered a Covered Medical Expense. The maximum Covered Medical Expense for confinement in an intensive care unit or a critical care unit will be the actual charge made by the Hospital.
   b. Other Hospital Services and Supplies. This means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the individual and required for the treatment of the individual.

      The term "Other Hospital Services and Supplies" does not include Hospital charges for room and board, or the professional services of a Physician or the services of a private duty nurse or any special nursing service.
2. Charges made by a Physician for his or her services. Such Physician's services may be rendered in or out of a Hospital and include surgical procedures, medical care and treatment, and second surgical opinions.
3. Charges for emergency transportation service by professional ambulance, up to the maximum amount listed in the Schedule of Benefits. In the event a person's disability requires specialized treatment, transportation for such treatment is covered. The transportation must be by regularly scheduled airline or railroad

or by air ambulance. The covered transportation is only from the city or town where the disability occurred to the nearest Hospital qualified to render the special treatment. This provision only provides for a trip from the place of disability to the nearest Hospital qualified to give special treatment which may or may not be the Hospital where the individual desires to be treated.

4. Charges incurred for treatment in a Walk-In Clinic.
5. Dental services rendered by a Physician for the treatment of a fractured jaw or of injury to natural teeth, including replacement of the teeth, provided the services are rendered within six months of and as a result of an Accidental Injury.
6. Nursing services rendered by a registered nurse, or by a licensed practical nurse if a registered nurse is not available, provided in either case the nurse is not a close relative of the individual receiving the services. Also, services must be pre-authorized by the Fund office, based upon the medical necessity and appropriateness of treatment of the nursing services rendered.

   The term "close relative" includes the spouse, child, grandchild, brother, sister or parent of the patient.
7. X-ray and laboratory examinations, x-ray or radium therapy treatments.
8. Services of a licensed physical therapist, speech therapist or occupational therapist, up to the limits outlined in the Schedule of Benefits.
9. Surgical dressings, casts, splints, trusses, braces and crutches.
10. Expenses incurred in connection with the purchase and fitting of orthopedic and prosthetic devices which are required either to replace a natural body part or to aid a body part in performing its natural function. Only such devices which are of a type that are in general use and are not experimental in nature will be covered. No payment will be made for such a device when a less costly device is available which will perform the basic functions generally required and expected of such a device. Covered under this provision will be the initial purchase of such devices, and replacements when necessary to replace a device which has ceased to function, or when necessitated by the growth of the covered individual. Covered expenses will not include any special articles of clothing associated with such devices.
11. Expenses charged by a Hospital for the routine care of a newborn and expenses charged by a Physician for in-hospital visits in connection with the routine care of a newborn during the confinement immediately following birth.
12. Physician charges for anesthesiology, radiology, pathology or other related services.
13. Covered Medical Expenses incurred in connection with kidney dialysis treatment.

14. Charges made by an Ambulatory Surgical Center.
15. Charges for Home Health Care.
16. Blood and blood plasma (if not replaced).
17. Services rendered by, or under the supervision of, a Doctor of Chiropractic (D.C.).
18. Charges for Hospice Care.
19. Charges made by an Extended Care Facility.
20. Purchase, or rental up to the purchase price, whichever is more cost effective, of the following durable medical equipment when required in the direct treatment of an illness or Accidental Injury or to aid in the recuperation from an illness, Accidental Injury or covered surgical procedure:
    a. Iron lungs or ventilation equipment of similar function and purpose.
    b. Manually operated hospital beds.
    c. Non-motorized wheelchairs.
    d. Crutches and walkers.
    e. Equipment used for the administration of oxygen (to include purchase of oxygen).
    f. Blood glucose monitors (to include purchase of necessary supplies).
    g. Nebulizers.
    h. Traction equipment.

EXCLUSIONS AND LIMITATIONS

The expenses listed below will not be considered a Covered Medical Expense under this provision:

1. Charges for any care and treatment of the teeth and gums except as expressly set forth under item (5) of Covered Medical Expenses.
2. Any charges incurred for eye refraction, eyeglasses, hearing aids or dental prosthetic appliances. However, if any of these services or items are required as the result of an Accidental Injury to a physical organ, and the injury occurred while the individual was eligible under this Plan, this exception will not apply.
3. Any charge that is incurred on account of any injury or sickness that happened as the result of war, or any act of war, whether or not war is declared. This exclusion also applies to any act of international armed conflict or any conflict involving the armed forces of any international body.
4. Any charge that is incurred as the result of any Accidental Injury, disease or illness for which benefits are payable under any Worker's Compensation Act or

any Occupational Diseases Act or any such similar law, or which are related to or due to the individual's occupation or employment.

5. Any charges that are incurred while an individual is confined in any hospital that is operated by the United States Government or any agency of the United States Government, except as may be required by law.
6. Any charges which are incurred by an individual which the individual is not legally required to pay.
7. Any charges incurred for education, training or room and board while an individual is confined in an institution which is primarily a school or institution of learning or training.
8. Any charges incurred while an individual is confined in an institution which is primarily a place of rest, a place for the aged or a nursing home.
9. Any charges incurred for any type of custodial care.
10. Any charges incurred for any treatment or surgical procedure or service performed that is of an elective nature. This exclusion applies to such items as cosmetic surgery and breast implants or reduction procedures. This exclusion does not apply to cosmetic surgery that is the result of an Accidental Injury which occurred to an individual while eligible under this Plan. This also does not apply to the correction of congenital defects or to corrective surgical procedures for conditions which prevent an organ of the body from performing and functioning properly or to vasectomies or sterilization procedures performed on beneficiaries other than Dependent Children. Reversals of vasectomies or sterilization procedures are not covered, however.
11. Any charges which are incurred for services, treatment, or surgical procedures rendered in connection with any overweight condition or condition of obesity.
12. Any charges incurred as a result of treatment by or consultation with a psychologist, social worker or marriage counselor.
13. Any charges incurred in connection with abortion procedures or pregnancy related conditions resulting in abortion unless such procedures are therapeutic in nature and are Medically Necessary to protect the life of the mother. However, in the event of medical complications arising from elective abortion procedures, charges resulting from treatment of such complications will be payable.
14. Any charge incurred for any drug or treatment prescribed or rendered for or in connection with cessation of smoking.
15. Any personal hygiene, comfort or convenience items such as humidifiers, exercise equipment, corrective shoes or orthopedic devices.

16. Any charge incurred for or in connection with treatment of any sexual dysfunction or condition of infertility.
17. Any charge incurred for or in connection with any treatment of temporomandibular joint dysfunction or syndrome by placement of an intraoral prosthetic or orthodontic device or any other method designed to alter vertical dimension.
18. Any charge incurred for, or in connection with, treatment of any behavioral problem, social maladjustment, attention deficit disorder or any antisocial action.
19. Any charge incurred in connection with any Experimental or Investigative treatment, procedure, facility, equipment, drugs, devices or supplies.

PRESCRIPTION DRUG COVERAGE — DRUG CARD PROGRAM

The fund provides coverage under this Schedule of Benefits for prescription drugs and medicines, including insulin and syringes used for its administration, through an arrangement with PCS Health Systems. You should have already been furnished with a drug card from PCS, along with a listing of participating pharmacies. Prescribed drugs are covered only when dispensed by a participating pharmacy or by the mail-order drug service available through PCS.

When drugs are purchased through a participating provider, whether through a local pharmacy or by mail-order, the co-payment amount listed in the Schedule of Benefits is applied to each prescription purchase. Coverage for prescription drugs is subject to all of the provisions of the contract in effect between the fund and the participating pharmacy network. Please refer to the information previously supplied to you which describes this program.

If you do not know whether your pharmacy participates in the PCS drug card program, you should ask the pharmacist, or you may contact the Fund office at 1-800-831-4914.

There are several drugs and related items which are excluded under this program. Some of those are:

1. Over-the-counter products;
2. Anti-wrinkle agents;
3. Blood and blood plasma;
4. Growth hormones;
5. Immunization agents;
6. Hair growth products;
7. Contraceptive implants;

8. Infertility medications;
9. Vitamins and other diet supplements or nutritional supplements;
10. Fluoride supplements;
11. Pigmenting/Depigmenting agents;
12. Anorectics; and
13. Alcohol swabs (most other diabetic supplies are covered).

STANDARD MEDICAL BENEFITS FOR BENEFICIARIES ELIGIBLE FOR MEDICARE

These benefits are provided to eligible beneficiaries who have not chosen to be covered through a health maintenance organization. (HMOs are not available in all areas covered by the fund.)

SCHEDULE OF BENEFITS

BENEFIT	WHAT THE PLAN PAYS
HOSPITAL BENEFITS (called Part A by Medicare)	100% of the Medicare Part A Deductible. 100% of the Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90 of Hospital confinement. 100% of the Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150 of Hospital confinement. After use of Lifetime Reserve Days, Plan pays 100% of the DRG amount or the Part A Medicare Eligible Expenses. Maximum is 365 additional days.
MEDICAL BENEFITS (called Part B by Medicare)	20% of the Medicare Part B Eligible Expenses, subject to Medicare's Part B Deductible. (The plan does not pay the deductible.)
BLOOD BENEFIT	Actual Expenses for the first three pints of blood each calendar year.
AT-HOME RECOVERY VISITS BENEFIT:	
Benefit Amount	Actual Expenses but not to exceed $40 per visit.
Maximum Benefit Amount	$1,600 per Calendar Year.
FOREIGN COUNTRY TRAVEL BENEFITS:	
Benefit Deductible	$250 per Calendar Year.
Benefit Amount	80% of the Medicare Eligible Expenses.
Lifetime Maximum Benefit Amount	$50,000

BENEFIT	WHAT THE PLAN PAYS
SKILLED NURSING FACILITY BENEFITS	Actual Expenses, from the 21st through the 100th day (this is the co-payment not paid by Medicare).
PRESCRIPTION DRUG PROGRAM	Generic and Brand Name Drugs listed on the Network's Preferred List are paid in full after a $7 co-pay. All other Brand Name Drugs, when Medically Necessary only, are paid in full after a $12 co-pay.

EXPLANATION OF BENEFITS

The benefits provided under this schedule are designed to supplement the benefits available under Part A and Part B of Medicare. Those benefits are limited to:

1. Benefit amounts which are approved by Medicare and which would otherwise be paid by Medicare except for the application of Medicare deductibles and co-payments. In other words, this part provides for the payment of the Medicare Part A deductible and the Medicare co-pays under Parts A and B. The Medicare Part B deductible is not covered under the plan.
2. Up to three pints of blood in each calendar year.
3. At-Home Recovery Visits (see definitions) subject to the limits outlined in the Schedule of Benefits.
4. Foreign Country Travel Benefits (see definitions) subject to the limits outlined in the Schedule of Benefits.
5. Prescription drug coverage as outlined below.

PRESCRIPTION DRUG COVERAGE — DRUG CARD PROGRAM

The fund provides coverage under this Schedule of Benefits for prescription drugs and medicines, including insulin and syringes used for its administration, through an arrangement with PCS Health Systems. You should have already been furnished with a drug card from PCS, along with a listing of participating pharmacies. Prescribed drugs are covered only when dispensed by a participating pharmacy or by the mail-order drug service available through PCS.

When drugs are purchased through a participating provider, whether through a local pharmacy or by mail-order, the co-payment amount listed in the Schedule of Benefits is applied to each prescription purchase. Coverage for prescription drugs is subject to

all of the provisions of the contract in effect between the fund and the participating pharmacy network. Please refer to the information previously supplied to you which describes this program.

If you do not know whether your pharmacy participates in the PCS drug card program, you should ask the pharmacist, or you may contact the Fund office at 1-800-831-4914.

There are several drugs and related items which are excluded under this program. Some of those are:

1. Over-the-counter products;
2. Anti-wrinkle agents;
3. Blood and blood plasma;
4. Growth hormones;
5. Immunization agents;
6. Hair growth products;
7. Contraceptive implants;
8. Infertility medications;
9. Vitamins and other diet supplements or nutritional supplements;
10. Fluoride supplements;
11. Pigmenting/Depigmenting agents;
12. Anorectics; and
13. Alcohol swabs (most other diabetic supplies are covered).

PRESCRIPTION DRUG ONLY BENEFIT FOR BENEFICIARIES ELIGIBLE FOR MEDICARE

This benefit is provided to Medicare eligible beneficiaries who have chosen to waive all other medical benefits available under the fund.

SCHEDULE OF BENEFITS

BENEFIT	WHAT THE PLAN PAYS
PRESCRIPTION DRUG PROGRAM	Generic and Brand Name Drugs listed on the Network's Preferred List are paid in full after a $7 co-pay. All other Brand Name Drugs, when Medically Necessary only, are paid in full after a $12 co-pay.

EXPLANATION OF BENEFITS

The fund provides coverage under this Schedule of Benefits for prescription drugs and medicines, including insulin and syringes used for its administration, through an arrangement with PCS Health Systems. You should have already been furnished with a drug card from PCS, along with a listing of participating pharmacies. Prescribed drugs are covered only when dispensed by a participating pharmacy or by the mail-order drug service available through PCS.

When drugs are purchased through a participating provider, whether through a local pharmacy or by mail-order, the co-payment amount listed in the Schedule of Benefits is applied to each prescription purchase. Coverage for prescription drugs is subject to all of the provisions of the contract in effect between the fund and the participating pharmacy network. Please refer to the information previously supplied to you which describes this program.

If you do not know whether your pharmacy participates in the PCS drug card program, you should ask the pharmacist, or you may contact the Fund office at 1-800-831-4914.

There are several drugs and related items which are excluded under this program. Some of those are:

1. Over-the-counter products;
2. Anti-wrinkle agents;
3. Blood and blood plasma;
4. Growth hormones;

5. Immunization agents;
6. Hair growth products;
7. Contraceptive implants;
8. Infertility medications;
9. Vitamins and other diet supplements or nutritional supplements;
10. Fluoride supplements;
11. Pigmenting/Depigmenting agents;
12. Anorectics; and
13. Alcohol swabs (most other diabetic supplies are covered).

BENEFIT DEFINITIONS

In order to properly explain each of the benefits to which you and your family may be entitled, it has been necessary to use certain specific terms in this booklet to describe those benefits. The definitions of many of those terms are as follows:

ACCIDENTAL INJURY

"Accidental Injury" means an injury sustained by an individual which results from and is caused by an event which is unexpected, fortuitous, violent and sudden and which is caused by an external force or object.

ACUTE ILLNESS

"Acute Illness" means an illness which:

1. arises suddenly,
2. is life-threatening, or might cause permanent impairment to the individual if immediate care is not sought, and
3. urgently requires the patient to seek immediate medical care such as that typically delivered in a hospital emergency room.

AMBULATORY SURGICAL CENTER

"Ambulatory Surgical Center" means a facility established for the purpose of performing surgical procedures on an out-patient basis only. "Ambulatory Surgical Center" may include such a facility established as a part of, or in connection with, a hospital, but only when that facility is maintained as a distinct entity and does not involve the use of the hospital's emergency room.

AT-HOME RECOVERY VISITS

"At-Home Recovery Visits" means those services provided to assist an individual in the activities of daily living while recovering in the home from a sickness or injury, subject to all of the following provisions. The individual's Physician must certify that the specific type and frequency of at-home recovery visits are Medically Necessary due to a condition for which a home care plan of treatment was approved by Medicare.

At-Home Recovery Visits are limited to:

1. the number and type of at-home recovery visits certified as Medically Necessary by the individual's Physician. The total number of such visits may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;
2. no more than seven visits in any one week;

3. care provided by a duly qualified or licensed home health aide/homemaker, a personal care aide or a nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;
4. care furnished on a visiting basis in the individual's home; and
5. visits received during the period the individual is receiving Medicare approved home care services, or no more than eight weeks after the service date of the last Medicare approved home health care visit.

"At-Home Recovery Visits" will not include any visits paid for by Medicare or other government programs or care provided by family members, unpaid volunteers or providers not described in 3. above.

COVERED MEDICAL EXPENSE

The term "Covered Medical Expense" means those expenses which are outlined in this booklet and which are actually incurred by a covered beneficiary for treatment of an illness, Accidental Injury or congenital defect, or in connection with the pregnancy of a retiree or the spouse of a retiree, or for the routine care of a newborn infant child of a retiree or the spouse of a retiree, or for a surgical sterilization procedure performed on a beneficiary other than a Dependent Child, subject to all the limitations outlined in this booklet. Further, "Covered Medical Expenses" are limited to those expenses which are Medically Necessary, and which are Usual, Customary and Reasonable Expenses as defined in this section.

EXPERIMENTAL OR INVESTIGATIVE

"Experimental" or "Investigative" means any treatment, procedure, facility, equipment, drugs, devices or supplies not yet generally recognized as accepted medical practice, and any such items requiring federal or other governmental agency approval and for which such approval has not been granted at the time services are rendered.

EXTENDED CARE FACILITY

"Extended Care Facility" means a licensed institution, other than a Hospital, which provides:

1. in-patient medical care and treatment to convalescing patients,
2. full-time supervision by at least one Physician or registered nurse,
3. 24-hour nursing service by licensed professional nurses,
4. complete medical records for each patient, and
5. utilization review plan for all patients.

It does not mean a home or facility used primarily for:

1. the aged,
2. the care of drug addicts,
3. the care of alcoholics,
4. the care and treatment of mental diseases or disorders,
5. custodial care, or
6. educational care.

FOREIGN COUNTRY TRAVEL BENEFIT

A Foreign Country Travel Benefit will be payable when a covered beneficiary receives medical care while in a foreign country, provided the care is rendered within the first sixty consecutive days of the individual's trip outside of the United States. Only those expenses which would have been considered Medicare eligible expenses, had the care been provided in the United States, will be considered under this benefit. This benefit will be payable only if the individual's primary residence is in the United States and the treatment rendered is for an injury or sudden and unexpected onset of a sickness requiring immediate medical attention. Benefits will not be payable for any charges incurred which the individual is not required to pay.

HOME HEALTH CARE

"Home Health Care" means the services and supplies described below which are required as an alternative to a Medically Necessary Hospital confinement. These services and supplies must be ordered by the covered beneficiary's attending Physician and must be administered in the beneficiary's home. Further, the attending Physician must certify in writing, to the satisfaction of the Benefits Board, that the Home Health Care treatment is of a type that would ordinarily be administered during confinement to a Hospital but can, under the circumstances, be safely administered in the home.

Home Health Care consists of the following services and supplies:

1. part-time or intermittent home nursing care from, or supervised by, a registered nurse,
2. part-time or intermittent home health aid services,
3. physical therapy and chemotherapy, and
4. medical supplies, drugs and medication prescribed by a Physician, and laboratory services, but only to the extent that they would have been covered during a Hospital confinement.

HOSPICE CARE

"Hospice Care" means care given to a terminally ill person by either of the following:

1. A hospice care agency which has hospice care available 24 hours a day and meets any licensing or certification standards set forth by the jurisdiction where it is located and which:
   a. provides:
      - skilled nursing services,
      - medical social services,
      - psychological and dietary counseling, and
      - bereavement counseling for the immediate family;

      or, arranges for other services which include:
      - services of a Physician,
      - physical or occupational therapy,
      - part-time home health aid services which mainly consist of caring for terminally ill persons, and
      - in-patient care in a facility when needed for pain control and acute and chronic symptom management;

   b. has personnel which include at least:
      - one Physician,
      - one registered Nurse,
      - one licensed or certified social worker employed by the agency, and
      - one pastoral or other counselor;

   c. establishes policies governing the provision of hospice care;
   d. assesses the patient's medical and social needs;
   e. develops a hospice care program to meet those needs;
   f. provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the agency;
   g. permits all area medical personnel to utilize its services for their patients;
   h. keeps a medical record on each patient;
   i. utilizes volunteers trained in providing services for non-medical needs; and
   j. has a full-time administrator.

or

2. A hospice care facility which is licensed or certified to provide in-patient hospice care and which:
   a. keeps a medical record on each patient;
   b. makes charges to its patients;
   c. has a full-time administrator;
   d. is run by a staff of Physicians of which one is on call at all times;

e. provides nursing services under the direction of a registered nurse 24 hours per day; and

f. provides an ongoing assurance program with reviews by Physicians other than those who own or direct the facility.

HOSPITAL

The term "Hospital" means an institution which is licensed as a hospital (if licensing is required by law where such institution is located) and which meets all of the following requirements:

a. It is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and maintains diagnostic and therapeutic facilities for medical diagnosis and treatment of such person by or under the supervision of a staff of duly qualified Physicians;

b. It continuously provides twenty-four (24) hour a day nursing service by or under the supervision of registered graduate nurses;

c. It has an operating room where surgical procedures are performed (unless the institution is a duly licensed psychiatric hospital);

d. It maintains daily medical records for each patient; and

e. It is not, other than incidentally, a clinic, convalescent home, institution for drug addicts or alcoholics, a place of rest, a place for the aged, or a nursing home.

In addition, for purposes of benefits paid under this plan for mental or nervous disorders, the term Hospital will include an institution which is accredited by a state licensing agency for the treatment of mental or nervous disorders and which has accommodations for resident bed patients, facilities for the treatment of mental or nervous disorders, a resident psychiatrist always on duty or call, and as a regular practice charges the patient for the expense of confinement.

MEDICALLY NECESSARY

The term "Medically Necessary" means those services, treatments or supplies provided by, or under the direction of, a Hospital or Physician that are required to identify or treat an injury or sickness and which are:

1. Consistent with the symptoms or diagnosis and treatment of the beneficiary's condition, disease, ailment or injury;

2. Appropriate according to standards of good medical practice;

3. Not solely for the convenience of a beneficiary, Physician or Hospital; and

4. The most appropriate which can be safely administered to the beneficiary.

PHYSICIAN

"Physician" means a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is legally qualified and licensed to practice medicine and perform surgery at the time and place the service is rendered. For covered services, Doctors of Dental Surgery (D.D.S.), Doctors of Dental Medicine (D.M.D.), Doctors of Chiropractic (D.C.), Doctors of Surgical Chiropody (D.S.C.), and Doctors of Podiatry (Pod.D.), when acting within the scope of their licenses, are deemed to be Physicians.

USUAL, CUSTOMARY AND REASONABLE EXPENSE

The term "Usual, Customary and Reasonable Expense" means the usual, customary and reasonable fees or charges for the covered services rendered and the covered supplies furnished as determined for the geographical area in which such services are rendered or supplies are furnished.

WALK-IN CLINIC

The term "Walk-In Clinic" includes clinics and centers which have been established solely for the purpose of treating minor medical emergencies and illnesses on an outpatient basis. Hospitals and other facilities which provide for treatment on an inpatient basis will not be considered Walk-In Clinics.

COORDINATION OF BENEFITS

The objective of this Coordination of Benefits provision is to limit the reimbursement from this plan and any other plan providing benefits to 100% of Covered Medical Expenses. Payments made by this Plan cannot be more than what would normally be paid if this provision did not exist.

When benefits are coordinated, they are reduced so that the maximum amount that is payable from this plan and any other plan does not exceed 100% of Allowable Expenses.

Benefits are coordinated with other group plans including the following coverages:

1. group, blanket, franchise insurance coverage,
2. hospital or medical service organizations, group practice, and other prepayment coverage,
3. any coverage under any labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plan, or
4. any coverage under governmental programs or any coverage required or provided by any statute.

ALLOWABLE EXPENSES

Benefits are paid under this Coordination of Benefits provision only for Allowable Expenses. In addition to expenses covered under this plan, Allowable Expenses include any Usual, Customary and Reasonable Expense that is covered under another plan. This does not mean that this plan would normally pay benefits for such expenses. It means that when expenses are calculated to determine the Coordination of Benefits payment, any charge that is covered under another plan, but is not considered covered under this plan, will, for this purpose only, be considered a Covered Medical Expense.

CLAIM DETERMINATION PERIOD

This Coordination of Benefits provision is administered on a calendar year basis. This calendar year basis for administration of the Coordination of Benefits provision is referred to as the Claim Determination Period. Any benefit savings resulting from this Coordination of Benefits provision in any calendar year will be held in a benefit account for that individual for that calendar year. Monies will be released from the benefit credit during that calendar year, if necessary, to give reimbursement of 100% of Allowable Expenses.

ORDER OF BENEFIT DETERMINATION

1. General. When there is a basis for a claim under this plan and another group plan, this plan is a secondary plan which has its benefits determined after those of the other group plan, unless:
   (a) The other plan has rules coordinating its benefits with those of this plan; and
   (b) Both those rules and this plan's rules, in Subsection 2. below, require that this plan's benefits be determined before those of the other plan.
2. Rules. This plan determines its order of benefit payment using the first of the following rules which applies:
   (a) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that, if the person is also a Medicare beneficiary, and Medicare is
      (i) secondary to the plan covering the person as a dependent, and
      (ii) primary to the plan covering the person as other than a dependent (e.g., a retired employee),

      then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

   (b) Dependent Child/Parents not Separated or Divorced. Except as stated in Section (c) below, when this Plan and another plan cover the same child as a dependent of different parents:
      (i) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
      (ii) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (i) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

   (c) Dependent Child/Parents Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      (i) First, the plan of the parent with custody of the child;

(ii) Then, the plan of the spouse of the parent with custody of the child; and

(iii) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge. When the plan with which this Plan is being coordinated does not contain the rules in this section, the plan covering the dependent as a dependent of a male will be the primary plan and the plan covering the dependent as a dependent of a female shall be the secondary plan.

(d) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in (b) above.

(e) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same will hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(f) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to Federal or state law also is covered under another plan, the following will be the order of benefit determination:

(i) First, the benefits of the plan covering the person as an employee, member or subscriber (or as that person's dependent);

(ii) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(g) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which has covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this provision of this plan or any provision of similar purposes of any other plan, this

plan may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person, any information, with respect to any person, necessary for such purposes. Any person claiming benefits under this Plan will be required to furnish to the Fund office such information as may be necessary to implement this provision.

RIGHT OF RECOVERY

Whenever payments have been made by this plan with respect to allowable expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Benefits Board has the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Benefits Board may determine: any persons to or for or with respect to whom such payments were made, any insurance companies, any other organization or any further claims made to this plan by a covered beneficiary

GENERAL

Under this Coordination of Benefits provision it is necessary that claim be made for any benefits the individual may be entitled to from any source. Whether or not claim is made to these other sources, this Coordination of Benefits Provision will be fully operable.

COORDINATION OF BENEFITS WITH MEDICARE

Regardless of any other provisions herein contained to the contrary, Coordination of Benefits with Medicare will be made in accordance with current applicable Federal laws and regulations.

ASSIGNMENT OF SUBROGATION RIGHTS

Situations sometimes arise where a Covered Person is entitled to benefits from this fund and also receives full payment of his medical bills from a third party. One example of this is medical bills arising from an injury received in an automobile accident where another party is held liable for the accident. That other party's insurance company may be liable to the employee for all of his medical bills, and that person could also submit those same bills to this fund and receive payment of benefits.

The Benefits Board of the fund has adopted a subrogation amendment to avoid this duplicate payment of medical bills. In this instance, subrogation means the assignment of legal rights to recover an amount from a third party where that party has been held responsible for medical bills which were paid by the fund. In the event of such a claim, the fund will still pay benefits due the covered beneficiary but only after receiving an assignment of subrogation rights from that person. The Fund will then be able to recover any amount paid for which a third party is liable.

The assignment of subrogation rights is administered as follows:

In the event of any benefit payments made by the plan, the fund will be subrogated to all the rights of recovery of the covered individual against any person or entity, of such payment. The covered individual will furnish any information or documentation required by the fund to secure such rights, and the covered individual shall do nothing after a loss to prejudice such rights.

If requested to do so in writing by the fund office, the covered individual will take any action necessary or appropriate to recover such payment as damages from any person or entity. Such action will be taken through a representative designated by the Benefits Board, and such action will be taken in the name of the individual involved. In the event of recovery or settlement, the fund will be reimbursed out of that recovery or settlement for expenses, cost and attorney's fees incurred by them in connection with such action. The right is hereby given the fund to receive from any third party, attorney or insurance company an amount equal to the amount paid on behalf of the covered individual.

The fund shall be entitled to the extent of any payment made to a covered individual to the proceeds of any settlement or judgment that may result from any recovery made by a covered individual against any person or entity legally responsible for the injury, sickness or condition for which such payment was made, or against any insurance carrier which may legally be required to make such payment under a no-fault automobile insurance contract.

The fund shall be entitled to the extent of any payment made to a covered individual, without regard to the characterization of such payment, to the proceeds of any

settlement or judgement that may result from the exercise of any rights of recovery of any covered individual against any person or entity legally responsible for the injury, sickness or condition for which such payment was made.

If the covered beneficiary makes a recovery from a third party and the fund is not reimbursed, the fund will have the right to recover such amount through any means available to the Benefits Board, including legal proceedings and offset against future claims.